



PATIENT REGISTRATION FORM

PATIENT'S NAME:		DATE OF BIRTH:	TODAY'S DATE:
ADDRESS:		CITY/STATE:	ZIP CODE:
SEX: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <input type="checkbox"/> OTHER	EMAIL ADDRESS:		
IF UNDER THE AGE OF 18, NAME OF PARENT/GUARDIAN:			
PHONE: HOME ()	CELL ()	WORK ()	
PREFERRED METHOD OF CONTACT: <input type="checkbox"/> HOME <input type="checkbox"/> CELL <input type="checkbox"/> WORK			
RACE/ETHNICITY: <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE		<input type="checkbox"/> ASIAN	<input type="checkbox"/> BLACK OR AFRICAN AMERICAN
<input type="checkbox"/> HISPANIC	<input type="checkbox"/> NATIVE HAWAIIAN OR PACIFIC ISLANDER	<input type="checkbox"/> WHITE	<input type="checkbox"/> OTHER: _____ <input type="checkbox"/> DECLINE
LANGUAGE: <input type="checkbox"/> ENGLISH <input type="checkbox"/> SPANISH <input type="checkbox"/> OTHER: _____			
PREFERRED PHARMACY:		PHARMACY PHONE ()	
EMPLOYER:		ADDRESS:	
SPOUSE/PARTNER'S NAME:		SPOUSE/PARTNER'S DATE OF BIRTH:	
EMERGENCY CONTACT (IF NOT SPOUSE):		PHONE ()	RELATIONSHIP:
HOW DID YOU HEAR ABOUT OUR PRACTICE?		REFERRED BY:	
METHOD OF PAYMENT: <input type="checkbox"/> INSURANCE <input type="checkbox"/> SELF-PAY (SKIP TO ASSIGNMENT OF INSURANCE BENEFITS)			
PERSON RESPONSIBLE FOR PAYMENT:		RELATIONSHIP:	
BILLING ADDRESS:		PHONE ()	
<i>PAYMENT REQUIRED AT TIME OF SERVICES/UNLESS PRIOR ARRANGEMENTS ARE MADE</i>			
1) PRIMARY INSURANCE:			
POLICY HOLDER'S NAME:		RELATIONSHIP TO PATIENT:	POLICY HOLDER'S DATE OF BIRTH:
I.D.#		GROUP#	
2) SECONDARY INSURANCE:			
POLICY HOLDER'S NAME:		RELATIONSHIP TO PATIENT:	POLICY HOLDER'S DATE OF BIRTH:
I.D.#		GROUP#	
OTHER COVERAGE:			
<i>\$25 Charge for all returned checks Cancellations with less than 24 hours' notice will result in a \$35 appointment fee Cancellations with less than 48 hours' notice for Procedure Appointments will result in a \$35 appointment fee</i>			

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical / medical benefits to PREMIER DERMATOLOGY/DR. ADIL USMAN for services rendered by him in person or under his supervision. I understand that I am financially responsible for any non-covered (cosmetic) services or balance not covered by my insurance. I am responsible for obtaining a referral or pre-certification for the office visit or a procedure if my insurance company/HMO/POS requires one. I will be charged full payment if I **DO NOT COMPLY**. I certify that the information given by me in applying for payment is correct and I request that payment of authorized benefits be made on my behalf. A photocopy of these assignments shall be as valid as the original

PATIENT NAME (PLEASE PRINT): _____ DATE: _____
 PATIENT SIGNATURE: _____
 PARENT/GUARDIAN NAME (PLEASE PRINT): _____ DATE: _____
 PARENT/GUARDIAN SIGNATURE: _____